CONFIDENTIAL

State of California
Extended Treatment Plan
BC-VOC-0251 (Rev. 12/99)

State Board of Control
Victims of Crime Program

Claim #	Date Form Sent
Victim's Name	**Claimant's Name**
Patient's Name	**Incident Date**

Return Form To:
Victims of Crime Program
P.O. Box 3036
Sacramento, CA 95812-3036

Or Your Local Victim/Witness Center Verification Unit

Please Print Clearly or Type

EXTENDED TREATMENT PLAN

ACCORDING TO OUR RECORDS, THIS PATIENT MAY STILL BE RECEIVING TREATMENT FROM YOU. IN ORDER FOR US TO CONSIDER CONTINUING PAYMENT FOR UP TO AN ADDITIONAL 25 SESSIONS OF ONGOING TREATMENT, YOU MUST COMPLETE THIS FORM.

If your Extended Treatment Plan (ETP) is not approved, reimbursement will be terminated and you will be notified of the number of sessions recommended for payment. Treatment that has already been provided at the time reimbursement is terminated will be paid, within the VOC Program's normal restrictions on payment (such as percent relatedness, per-session limits, and restrictions on types of charges).

If your patient will be terminating treatment on or before the session limit at your current level of authorization, you may complete this form by answering questions 1-13 only. This form must accompany your closing bill.

Place a check in the LEFT column below to show how many sessions you have completed with this patient. If this Extended Treatment Plan (ETP) is approved, it will authorize additional sessions up to the maximum number in the corresponding column to the RIGHT.

❒ 1-30 sessions	(The maximum number >	31-55 sessions
❒ 31-55 sessions	of additional sessions >	56-80 sessions
❒ 56-80 sessions	this ETP will authorize >	81-105 sessions
❒ 81-105 sessions	IF it is approved is:) >	25 Additional sessions
❒ Over 105 sessions		25 Additional sessions

❒ **Patient will be terminating on or before the current session limit.**

1. Name of Patient	2. Name of Victim	3. Patient's Relationship to Victim
4. Name of Therapist	**5. Provider Organization Name**	**6. . License/Registration # and Expiration Date**

7. Check Appropriate Box for Title of License/Registered Therapist (refer to #6)

❒ LMFT	❒ LMFT Intern
❒ LCSW	❒ ASW
❒ Licensed Clinical Psychologist	❒ Registered Psychologist
❒ Licensed Psychiatrist	❒ Resident in Psychiatry
❒ Psychological Assistant Intern	❒ Other (Please specify):

8. Name and Title of Supervising Therapist (If applicable)	9. License #	10. Expiration Date

11. Date of current report:	12. Date of previous report:

13. Is this a termination report?

❒ **No Skip to question 14.**

❒ **Yes Please complete a, b, and c below, and submit this signed form with your closing bill.**

a. Please describe this patient's discharge status:

❒ **Unplanned termination**

❒ **Chief complaints mainly resolved**

❒ **Treatment deferred until a later time**

❒ **Referral to another mental health provider**

❒ **Other (Please specify): _____**

b. Please note this patient's "global assessment functioning" (GAF-AXIS V) at the time of discharge: _____

BEFORE COMPLETING THIS SECTION, PLEASE REFER TO THE "RESTITUTION HEARING" INFORMATION ON THE LAST PAGE OF THIS FORM

c. In your opinion, what percentage of your treatment was necessary to address the effects of the qualifying crime? (Note: It is understood that in the initial phase of treatment (i.e., first 30 sessions), your treatment may be focused on conditions which were caused directly by the qualifying crime as well as on pre-existing conditions which were exacerbated by the crime.)

❒ **Less than and including 50%**

❒ **More than 50%**

❒ **100%**

14. Number of sessions since the last report (Initial or Extended Treatment Plan):

Individual sessions:

Group sessions:

Family sessions:

Other (Please specify): _____

15. Do you wish to revise any of the information on the multi-axial diagnosis given since your last report (Initial or Extended Treatment Plan)? (Note: Be sure to note any changes on Axis V.)

❒ **No change**

❒ **Revise as follows:**

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

16. In the past 6 months, has this patient exhibited any of the following symptoms at a level that you consider clinically significant? Please check all that apply.

- ❒ Aggression
- ❒ Anger
- ❒ Anxiety
- ❒ Apathy
- ❒ Avoidance
- ❒ Behavior problems
- ❒ Compulsive behavior
- ❒ Crying
- ❒ Denial
- ❒ Depression
- ❒ Difficulty concentrating
- ❒ Disordered eating symptoms
- ❒ Dissociation
- ❒ Emotional numbing
- ❒ Fear
- ❒ Flashbacks
- ❒ Guilt
- ❒ Harm to others/threats to others
- ❒ Hyperactivity
- ❒ Hyperarousal
- ❒ Insomnia/sleep problems
- ❒ Irritability
- ❒ Memory problems
- ❒ Nightmares
- ❒ Obsessive behavior
- ❒ Panic
- ❒ Phobias
- ❒ Self-blame
- ❒ Self-destructive relationships
- ❒ Self harm behaviors/impulses
- ❒ Sexual acting out
- ❒ Sexual dysfunction
- ❒ Somatic complaints
- ❒ Substance abuse withdrawal
- ❒ Other: _____
  _____

17. Do you wish to revise the rating given for the patient on the previous report for the SOFAS scale? (Note: Rate the relational unit in which this patient resided during the period of time covered by this progress report.)

- ❒ No change
- ❒ Revise as follows: _____

18. Do you wish to revise the rating given for the patient on the previous report for the GARF scale? (Note: Rate the relational unit in which this patient resided during the period of time covered by this progress report.)

- ❒ No change
- ❒ Revise as follows: _____

19. In your opinion, what were the most important interventions in your treatment of the patient since your previous report (Initial or Extended Treatment Plan)? Please describe the interventions.

20. Please identify any of the following factors which may interfere with treatment during the next 3 months.

	No/not applicable	Yes
Mental status	❒	❒
Personal history	❒	❒
Support system	❒	❒
Justice system status	❒	❒
Family integrity	❒	❒
Economic/employment status	❒	❒
Other: _____	❒	❒

If you answered "yes" to any factor(s) above, please explain.

21. List below the treatment goals you established at the time of the Initial Treatment Plan and estimate for each the percentage of the goal that has been completed.

Goals	Percentage Completed 25%	50%	75%	100%
1.				
2.				
3.				
4. Other (Please specify):				

22. Please note any changes you wish to make in the goals for the next treatment period.

Add:

Delete:

23. If your treatment focus included conditions which were not originally caused by the crime but which all were exacerbated by the crime such that they now require attention, please describe those conditions and the way(s) in which they were exacerbated. (Note: After the initial phase of treatment, continuing treatment of pre-existing conditions can affect your reimbursement, if it is determined that such treatment is not necessary for the patient's recovery from the qualifying crime.)

24. Given the present circumstances in this case, please estimate the number of sessions you believe will be required before the client can be considered for discharge from treatment: _____

Pursuant to Government Code section 13965(a)(1) a private nonprofit agency that treats victims referred by a public agency at reduced cost may be reimbursed at their normal and customary fee not to exceed the maximum rates set by the Board.

As required by law, the information requested by the State Board of Control (Board), which administers the VOC Program, must be returned to the Board within 10 business days. The Board verifies that: (1) this is a verification form requesting information that must be provided at no cost to the patient, the Board, or local Victim/Witness Assistance Centers, and (2) that we have a signed authorization on file for the release of the information requested. (Government Code Section 13962(b))

RESTITUTION HEARING

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for the victim. Although this will occur infrequently, the treating therapist must be prepared to testify in a restitution hearing that all mental health counseling expenses paid by the Board were necessary as a direct result of the crime.

IMPORTANT: Required Signature(s) Below MUST Be Provided.

DECLARATION

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form, and to the best of my information and belief, all my answers are true, correct and complete, and; (2) all treatment submitted for reimbursement by the Board on behalf of the victim was necessary as a direct result of the crime described on the patient's original Initial Treatment Plan. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

Treating Therapist:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

If Registered Intern:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Supervising Therapist's Signature: _____ Date: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____